This leads to the second issue—the regional distribution of adipose tissue. From the pioneering studies of Vague[2] to the more recent studies in the laboratories of Björntorp[3] and Kissebah,[4] it has become clear that the mechanisms and the metabolic and medical consequences of abdominal adiposity ("android," or upper body) are vastly different from those of adiposity distributed mainly around the hips and thighs ("gynoid," or lower body). Abdominal obesity tends to have its onset in adulthood and is associated with potentially reversible adipocyte hypertrophy, while lower body obesity tends to be lifelong and associated with less readily reversible adipose cell hyperplasia. While large population studies uniformly show increased mortality at body weights about 30% above arbitrary standards, newer data suggest that many of the major causes of death—premature coronary heart disease, diabetes, hypertension—are predominantly associated with abdominal obesity. Fortunately, in the measurement of the waist-to-hip ratio, we have a simple, inexpensive, noninvasive test requiring a minimum of equipment (a tape measure) and minimal need for standardization. Focus must now be on the metabolism of abdominal (particularly abdominal visceral)[5] fat cells in these persons and, at the least, mechanisms for insulin resistance.

The newer insights have important implications for treatment, since we seem to be on the verge of new approaches and new methods of therapy. Bray and Gray, in the second of their two articles, to be published in the November issue of the journal, emphasize, however, that current treatment modes are palliative, not curative, and that recidivism is the rule. This may reflect problems inherent in the current approaches that consider obesity as a single entity for purposes of treatment. Perhaps we would be more successful if we intensively managed those patients at highest risk for the consequences of obesity, such as those with abdominal obesity, and defer attempting nutritional and behavioral approaches for those with lifelong and lower body obesity. This might not be acceptable cosmetically, but it may increase our therapeutic success and, more important, reduce the morbid consequences summarized in the two articles.

Those subsets of obese persons that would appear to benefit most from successful therapeutic attempts at weight reduction include all with an abdominal distribution of adiposity (high waist-to-hip ratio), those with hypertension, type II diabetes, and with certain forms of genetic hyperlipidemia, particularly familial-combined hyperlipidemia.[6]

Modes of therapy for obesity have not really changed in the last decade, except for refinement of nutritional, behavioral, and operative approaches. Drug therapy is still based largely on catecholamine neurotransmitters to suppress appetite and has had little long-term success in maintaining reduced weight. It is associated with a plethora of side effects and a varying propensity for abuse. Drug-enhanced thermogenesis, thyroid in pharmacologic doses, for example, is not useful, since a decline in lean body mass usually exceeds that of fat mass. Fooling the gut by ingesting nonabsorbable materials, such as fiber or sucrose polyester, is likely to result in an increase in intake of absorbable nutrients over the long term to maintain body adipose mass.

We eagerly await the development of new tools that focus on alteration of the endogenous determinants of energy expenditure and its coupling to energy intake. When applied to appropriate subsets of the obese population, newer approaches can be expected to improve the long-term goal of maintaining reduced adiposity.

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A Fantasy of the Future

AT THIS WRITING there seems to be little doubt that a fundamental change is taking place in the Soviet Union, change that was unthinkable only a short time ago. How deep the change is, or how long it will last, we do not yet know, but what we have seen so far could be described as the beginning of an "Americanization" of the Soviet Union, with more permitted in the way of openness, free expression, contested elections, and even some free enterprise. One can sense the beginning of a military retrenchment around the world. If all of this and more is for real, then it could be viewed as a major victory for the free world in what has been an ideologic struggle that threatened the destruction of humankind.

If one recalls some history that is within the memory of many of us, this will not be the first time that "Americanization" has come about in nations that sought to impose their way of life on the rest of the world. After Germany and Japan were vanquished in World War II, both West Germany and Japan subsequently adopted many American ways of doing things. Since the Korean War much the same thing has happened in South Korea. And most significantly, each of these nations, through determination and hard work, has become a formidable economic competitor of America. Some think they may even be outdoing us at our own game!

Now the Soviet Union seems to be trying its hand at some of the American ways of doing things. It is conceivable that much the same thing may happen in China, Central and South America, and perhaps eventually even in India.

One can wonder if we are not somehow shackling ourselves unduly with too many laws and too much paralyzing litigation that sap our vigor, in a sense trying to compete with the rest of the world with one hand tied behind our back. Health care is a case in point. There is growing evidence that too many laws, too much litigation, and too much regulatory interference have already begun to sap the vigor and effectiveness of health care in this nation. The national priorities, whether in health care or in the preparation of our youth to meet the challenges of the future that is before us, seem to fall considerably short of what one would hope and expect if this nation expects to compete effectively in an "Americanized" world that we will have done so much to create. MSMW